Release of Information

I, _____, authorize the
(Please print your name)
Maricopa County Department of Public Health / Office of Oral Health to release necessary information to

*_____/*_____Name
of your case management agency/agencies / Name of your dental provider

***IF YOU DO NOT HAVE A CASE MANAGEMENT AGENCY OR DENTAL PROVIDER WRITE NONE IN THESE BLANKS.**

regarding enrollment and administration of the Maricopa County Department of Public Health / Group # 2365 Delta Dental of Arizona Insurance Plan. This release is valid for up to five (5) years.

I further understand that persons reviewing my records will hold all information in confidence.

Client Signature: _____

Date: _____

Witness Signature: _____

Revised 2/13/03:Release English